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Published in:
World Journal of Gastroenterology

DOI:
10.3748/wjg.15.2423

Citation for published version (APA):
Biliary drainage of the common bile duct with an enteral metal stent

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INTRODUCTION
Biliary drainage of inoperable malignant bile duct obstruction by a metal stent is preferred over plastic stents due to longer patency[1]. Unfortunately, even metal stents can become dysfunctional[2]. Usually a second stent (metal or plastic) is placed[3] or an attempt to remove the stent endoscopically can be made[4]. We report a case of relapsing cholangitis after placement of 5 metal stents. Removal of the metal stents and insertion of an enteral stent in the common bile duct (CBD) regained adequate drainage.

CASE REPORT
An 84-year old woman was referred to our hospital with recurrent episodes of cholangitis that persisted after placement of five metal stents for a distal common bile duct (CBD) stenosis. All metal stents were endoscopically removed from the CBD by forceps after balloon dilatation of the papilla. A profoundly dilated CBD with sludge and concrements was seen. To ensure adequate bile drainage an enteral metal stent was inserted in the CBD. This case shows that proximally migrated uncovered metal stents in the CBD can be safely removed endoscopically under certain circumstances. We suggest that in the case of a CBD drainage problem due to an extremely dilated CBD, placement of an enteral metal stent in the common bile duct (CBD) could be considered, especially in patients who are unfit for surgery.

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Key words: Cholangitis; Dilated common bile duct; Endoscopic retrograde cholangiopancreatography; Enteral metal stent; Metal stent removal

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performed balloon dilatation (18 mm CRE balloon, Boston Scientific International S.A., Nanterre Cedex, France) of the sphincter and the relatively narrow distal CBD to 18 mm. We encountered four metal stents that had been overlapping. The stents were subsequently removed with foreign body forceps. With a balloon and crusher the majority of the concrements and debris was removed. Given the extreme dilatation of the CBD, up to 5 cm in diameter, with a profound angulation of the distal CBD and in retrospect no malignant stricture, an enteral metal stent was placed (WallFlex enteral duodenal stent 22 mm × 60 mm, Boston Scientific Corporation, Natic, USA) to prevent further obstruction by kinking. This left the patient with a widened CBD with a secondary distal angulation contributing to recurrent obstruction. Normally a hepaticojejunostomy would solve these problems, however, her general condition combined with her age forced us to look for other options. We chose to place a large diameter enteral metal stent in the distal CBD to avoid dislocation and kinking of the widened CBD. This procedure was successfully used by Diehl et al. to stent a wide CBD due to a choledochal cyst. In our patient we achieved adequate drainage, the stent remained in position and no recurrence of cholangitis has occurred for more than 6 mo.

Proximally migrated uncovered metal stents in the CBD can be safely removed endoscopically under certain circumstances. We suggest that in the case of a CBD drainage problem due to an extremely dilated CBD, placement of an enteral metal stent in the CBD could be considered, especially in patients who are unfit for surgery.

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